



NEW AVENUES / MBHN: Outpatient Treatment Report – Authorization Request

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 Midwest Behavioral Health Network · P.O. Box 360, South Bend, IN 46624 · Phone: (866) 925 - 5730 · Fax: (574) 271 – 5980

Fax to MBHN before your authorization expires. Only Page 1 required for treatment to be completed within 20 visits. Complete Page 1 and 2 for treatment that is anticipated to be longer than 20 visits.

I. Demographics: Date of Request: _____

Client Name: _____ Birth Date: _____ Case #/ SSN _____

Health Plan: _____ Provider's Agency: _____

Provider Name (Print) _____ Provider Signature: _____

II. Medication: (List all psychotropic & other medications) **Not Assessed** []

Has the patient been evaluated for medication? Yes No Prescribing Physician: _____

Current Medication: None Psychotropic Medical Other: _____

<u>Medication</u>	<u>Dosage/Frequency</u>	<u>Start Date</u>	<u>Medication</u>	<u>Dosage/Frequency</u>	<u>Start Date</u>
① _____			⑤ _____		
② _____			⑥ _____		
③ _____			⑦ _____		
④ _____			⑧ _____		

Patient is compliant with medications: Yes No Partial compliance

This patient has not been evaluated for medications, but am recommending evaluation: with PCP with a Psychiatrist

III. Treatment Focus: What realms of distress, symptoms, and/or impairment require continued treatment? For each realm, describe the problem(s) to be addressed in treatment as related to the diagnosis. If the realm is not affected, state "Not Applicable".	Level of Distress/Impairment 1 - Severe 2 - Significant 3 - Moderate 4 - Mild	Progress To Date 1 - No Change 2 - Mild Change 3 - Moderate Change 4 - Pronounced Change 5 - Problem Resolved
Psychological /Emotional Symptoms		
Physical Symptoms: Changes in appetite, sleep, energy or somatic concerns		
Behavioral Disturbances/Concerns		
Relationship Issues		
Cognitive Functioning		
ADL/Occupational/School Performance		
Substance Abuse/Compulsive Maladaptive Behaviors		
List Any Other Complicating Factors or Stressors:		

IV. DSM-IV Diagnosis: (required)

AXIS I: Primary: _____ Secondary: _____

AXIS II: Primary: _____ Secondary: _____

AXIS III: _____

AXIS IV: _____

AXIS V: (current GAF): _____

AXIS V: (past year GAF): _____

Presence of Risk Factors:

Trauma: Recent or Historical

Abuse of alcohol, prescribed or non-prescribed medications, or use of illegal substances

Suicide ideation/intent/ attempts within last 90 days

Experience of Serious Loss(es) within last 12 months

Other factors

V. Provider Coordination of Care with PCP:

Check all that apply.

Patient has signed consent form to allow communication

Verbal communication with PCP was made on this Date: _____

Written communication with PCP was made on this Date: _____

Patient declined to sign consent form

I have not discussed consent form with Patient

I have not communicated with PCP

VI. Request for Approval of Visits:

Procedures Codes	# Units	Start Date	End Date
90806	_____	_____	_____
90846 / 90847	_____	_____	_____
90853	_____	_____	_____
IOP - MH	_____	_____	_____
IOP - SA	_____	_____	_____
List Other Codes:	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If treatment is to be completed in 20 visits, fax Page 1 to MBHN. If treatment is expected to be more than 20 visits, Pages 1 & 2 required. MBHN Fax: 574-271-5980

VII. Current Treatment Plan:

A. **GOAL #1:** _____
GOAL #2: _____
GOAL #3: _____

B. **Treatment Modalities:** Individual Family Group IOP-MH IOP-SA Medication Management Other

C. **Frequency:** Weekly 2 times/week 3 times/week Bi-weekly Monthly Quarterly As needed Other

D. **Progress: What are your measures of progress?** Example: Frequency of panic attacks, Number of days of sobriety, Number of hours of sleep, etc.

E. **If progress has been limited as demonstrated by lack of improvement in GAF score, minimal symptom relief, lack of response to treatment, what are the reasons?**

F. **Are there any barriers or mitigating circumstances affecting progress?**

G. **Is patient compliant with Treatment Plan, with medications, with assignments, and with appointments?** Yes Partial No - If "No" Describe Patient motivation or resistance levels.

H. **What methods, treatment modalities, or approaches are you using during proposed next phase of treatment?** (Eg.: Cognitive Behavioral, EMDR, DBT, Family Therapy)

I. **What outcomes are you expecting?** (check all that apply)
 Symptom reduction & discharge from active treatment.
 Return to highest level of functioning before onset of current problem(s) & discharge from active treatment.
 Transfer to self-help group or other support services & discharge from active treatment.
 Provide ongoing supportive counseling in order to maintain stabilization of symptoms and functioning.

J. **Is Treatment Plan consistent with APA or nationally recognized Clinical Guidelines?** Yes No

VIII. Comprehensive Treatment Planning:

A. **Has your Treatment Plan been coordinated with any other treating Provider?** PCP Psychiatrist Treatment Program Other

Are you recommending any additional services such as:

Psychiatric Consultation Psychological Testing EMDR Consultation Substance Abuse Assessment Medical Evaluation/Consultation Self-Help Groups

B. **Expected Date of Completion (Month/Year):** _____ **Expected total number of additional sessions to complete treatment?** _____

PROVIDER'S SIGNATURE: _____ **AGENCY:** _____ **DATE SIGNED:** _____